Virginia Health Practitioners' Monitoring Program
PRN Psychiatrist/Addiction Medicine Physician Report

Name of Participant: _____ **Client #** _____ **CM:** _____

Date of Report: _____ **For Month:** _____, 20_____

Conditions being treated:
For the above named individual, please provide your current, full Axis I–V diagnoses:

		New	Ongoing	Resolved
Axis I:	_____	☐	☐	☐
	_____	☐	☐	☐
	_____	☐	☐	☐
	_____	☐	☐	☐
Axis II:	_____	☐	☐	☐
	_____	☐	☐	☐
Axis III:	_____	☐	☐	☐
	_____	☐	☐	☐
Axis IV:	_____	☐	☐	☐
	_____	☐	☐	☐
Axis V:	_____			

Please list currently prescribed medications: **Medication levels/Lab work:**

Medication:	Dose:	Date:	Test:	Result:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Psychiatrist visits: Number of appointments scheduled for month: _____ Dates attended: _____

Please tell us your assessment of how this individual is doing in treatment since last month (or the last report you filed) and provide comments which support your assessment: ☐ First Report
☐ Much Worse ☐ Somewhat Worse ☐ Same ☐ Somewhat Improved ☐ Much Improved

Is the participant compliant with treatment/medications? ☐ Yes ☐ No

Comments: _____
_____
_____

Do you need more information about the Virginia Health Practitioners' Monitoring Program (HPMP) or participant? ☐ Yes ☐ No

Do you need to speak with the participant's case manager? ☐ Yes ☐ No

As far as you are aware, is the participant practicing a health profession? ☐ Yes ☐ No

Do you have any concerns about the participant's ability to practice his/her health profession? ☐ Yes ☐ No

I have a copy of the participant's RMC # _____

Person Completing Report (Print Name): _____ Date: _____

Signature: _____ Telephone: _____

(Please fax this form to 804-828-5386 after each visit.)
Thank you for your cooperation!

For Office Use Only
Date Received by HPMP: _____ Case Manager: _____